STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155459	A. BUILDING 00 B. WING	04/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY CREEK AT NEW CASTLE	901 N 16TH ST NEW CASTLE, IN47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: April 18, 19, 20, & 21, 2011 Facility number: 000341 Provider number: 155459 AIM number: 100286550 Survey team: Angel Tomlinson RN TC Karina Gates Medical Surveyor Leslie Parrett RN Barbara Gray RN [April 21, 2011] Census bed type: SNF/NF: 32 Total: 32 Census payor type: Medicare: 2 Medicaid: 22 Other: 8 Total: 32 Sample: 10 These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed 4-26-11	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Cathy Emswiller RN			
F0221 SS=D	The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Based on observation, interview, and record review, the facility failed to ensure a resident had medical symptoms that warranted the use of a restraint and the restraint was not imposed for purposes of convenience for 1 of 1 sampled residents reviewed for restraints in a total sample of 6 (resident #35). Findings included: Review of the record of Resident #35 on 4/19/11 at 11:10 a.m. indicated the resident's diagnoses included, but were not limited to, anxiety, insomnia, Alzheimer's disease with dementia, hypertension, asthma, rheumatoid arthritis, and macular degeneration. The physician order dated 2/1/11 indicated D.C. (discontinue) self release belt. Lap tray on when up in W.C. (wheelchair) due to decreased safety	F0221	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Hickory Creek at New Castle desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on 5-21-11. *F221 It is the policy of this facility that all residents have the right to be free of any physical restraint imposed for purposes of convenience*. 1. What corrective action will be done by the facility? The lap tray for resident #35 was discontinued on 5-03-11. This resident exhibits weakness of the Rt. arm secondary to a history of TIA. A therapy screen was requested, and a right hemi tray was recommended for positioning of the Rt. arm. The Physician	05/21/2011

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	awareness 2nd (secondary) to diagnosis of Alzheimer's with Dementia et (and) behaviors. The Minimum Data Set (MDS) assessment for Resident #35 dated 4-8-11 indicated the following: ability to make self understood - usually understood, ability to understand others - usually understands, disorganized thinking - behavior continuously present, does not fluctuate, physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) - behavior not exhibited, verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others) - behavior not exhibited, other behavioral symptoms not directed toward others - behavior not exhibited, rejection of care - behavior not exhibited, transfer - 2 + persons physical assist, walk in room - activity did not occur, any falls since prior assessment - no, mobility devices - wheelchair, physical restraint - chair prevents from rising/used daily. The restraint care plan dated 2/1/11 indicated a goal of "will have no falls or injuries" and an intervention dated 4/14/11 of "remove lap tray during the day when in hallway by nurse's station if not agitated."		was notified of the recommendation and an order was received for its use. In addition a wedge cushion was also put into place to assist with the resident's positioning. The family was notified and the care plan revised. Nursing staff will be in-serviced by 5/21/11 regarding the appropriate use of physical restraints, including the requirement for documented medical symptoms. They will also be i-serviced on alternatives to physical restraint use. 2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? No other resident was affected by this deficient practice. However, if the DON or designee observes a physical restraint being used for a resident, she will check the medical record at that time to make sure that all required items are in place, including documentation of medical symptoms that require the use of the restraint. If there are none present, she will have the staff remove the restraint immediately. The DON will then re-train the staff involved regarding the facility policy and procedure for physical restraint use. She will also render progressive disciplinary action to staff involved for continued non-compliance. 3. What measures will be put into place to ensure this practice does not	

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	During observation on 4-19-11 at 2:38 p.m., CNA #1 and CNA #2 verbally encouraged resident #35 to sit in a recliner in the resident's room. Resident #35 held onto the doorknob and refused. At 2:40 p.m., CNA #1 attached the lap tray to resident #35's wheelchair and pushed her into the hallway in front of the nurse's station. Nurse's note dated 4/14/11 at 2:40 p.m. indicated "Resident in hall @ [at] nurse desk with lap tray on. No attempt made to get (arrow pointing up) on own noted." Nurse's note dated 4/14/11 at 9:00 p.m. indicated "Tray off til res started moving self a lot bending (arrow pointing down) etc. Tray then put on." Nurse's note dated 4/12/11 at 10:00 p.m. indicated "tray placed on d/t (due to) res. reaching over quite a lot 90 degrees. Picking at tray velcro. Agitated, restless still refusing meds." Interview with the DON (Director of Nursing) on 4/19/11 at 2:50 p.m. indicated resident #35 could not remove the lap tray. When asked about the behaviors the restraint had to justify the use of the restraint, the DON indicated the resident gets agitated. The DON indicated the		recur? Prior to applying a restraint a screen will be requested by the therapy dept. to determine the appropriate device. If an evaluation is needed the Physician will be notified. Any newly initiated physical restraint use will be brought by the DON to the next scheduled morning meeting (which occurs at least 5 days a week) for discussion and review by the IDT (interdisciplinary team). The resident will be evaluated by the IDT regarding the resident's mental status, behaviors, and medical diagnosis. Other interventions will also be considered to keep the resident safe. 4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The DON will bring any physical restraint use to the monthly QA&A Committee for review and recommendation. Any recommendations regarding the continued use or discontinuation of the physical restraints will be made by the QA&A Committee members. The DON will follow up as requested by the Committee members and will report the status of the physical restraint recommendations to them at the next scheduled QA&A Committee meeting. This will continue on an ongoing basis. Date of Compliance: 5-21-11	

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	resident tries to get up and doesn't realize she can't walk anymore and that she's combative. When queried about other interventions tried prior to a restraint, the DON indicated a wedge cushion, a self release belt, and a chair alarm. She stated, "We decided to put the lap tray on because she was releasing the velcro belt at night and because she has a history of falls." The DON indicated the resident's last fall was on 1/6/11. The falls care plan dated 8/10/10 indicated the resident was at risk for further falls due to a diagnosis of Alzheimer's disease and the resident tries to get up by herself. One approach indicated in the care plan was to use a lap tray on while in wheelchair and taken off during meals and to Take the tray off during the day when in hallway by nurse's station if not agitated. During interview with family member #1 on 4/19/11 at 12:10 p.m., family member #1 stated, "The restraint does aggravate her at times. She doesn't understand it. I guess it's the lesser of two evils." The manufacturer's guidelines provided by the DON on 4/20/11 indicated "Skil-Care wheelchair lap trays are designed to serve as therapeutic interventions that assist patients in			

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	achieving proper body position, balance and alignment. Although most residents can remove Skil-Care trays, there are some who cannot. For them the trays could be considered as restraints. The "Physical Restraints" policy provided by the DON on 4/20/11 at 10:15 a.m. indicated "each resident has the right to be free from any physical restraints, including the use of seclusion/isolation, imposed for the purposes of discipline or convenience, and not required to treat the resident's medical symptoms". The policy defines physical restraints as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. The policy defines convenience as any action taken by the facility to control a resident's behavior or manage a resident's behavior with a lesser amount of effort by the facility and not in the best interest of the resident. The policy procedure states "regarding medical symptoms, the resident's subjective symptoms may not be used as the sole basis for using a restraint. In addition, the resident's medical symptoms should not be viewed in isolation; rather, the symptoms should be viewed in the context of the resident's condition,			

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	circumstances, and environment. Falls do not constitute self-injurious behavior or a medical symptom that warrants the use of a restraint." 3.1-3(w)			
F0250 SS=D	The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based observation, interview and record review, the facility failed to follow up with the primary care physician for a resident with a new diagnosis of depression and was experiencing signs and symptoms of depression for 1 of 3 residents sampled for depression in a total sample of 10 (Resident #28). Finding include: Review of the record of Resident #28 on	F0250	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Hickory Creek at New Castle desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on 5-21-11.	05/21/2011

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	4-20-11 at 8:10 a.m. indicated the resident's diagnoses included, but were not limited to, craniotomy, Parkinson, respiratory failure, anxiety and depression. The Minimum Data Set (MDS) assessment for resident #28 dated 3-10-11 indicated the following: ability to understand others- understands, makes self understood- understood, feeling tired or having little energy was present and frequent, transfer- extensive assistance of two people, walk in room- did not occur, dressing- extensive assistance of one person and toilet use- extensive assistance of two people. The social history for Resident #28 dated 6-28-10 indicated the resident was married for forty years and his wife died from Huntington disease. The resident adopted one daughter that passed away in June 2010. The resident was remarried and was now in the process of a divorce. The care plan for Resident #28 dated 3-23-11 indicated "I feel depressed at times and do not always want to be around others or interact with them. The interventions included, but were not limited, Psychological Laboratories of Indianapolis (PLI) case management.		*F250* *It is the policy of this facility to provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, including any necessary follow up with attending physicians regarding residents' signs and symptoms of depression.* 1. What corrective action will be done by the facility? An order was received on 4-21-11 for Resident #28 to begin Zoloft 25mg for 1 week then increase to 50mg daily thereafter. The licensed nurses were in-serviced on 5/3/11 on the facility expectation that physicians are notified immediately when there is a change in a resident's condition. In addition, if the nurse faxes a physician regarding a resident's condition, there will be continued follow up, as described in question #3, until a response to the fax has been received by the facility. 2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? A chart audit of those residents receiving psychiatric services was performed, and no other resident was	

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	The PLI mental status report for Resident #28 dated 12-28-10 indicated the resident was alert and oriented to person, city and nature of facility and current month. The resident reported feeling depressed mood and poor sleep. The diagnosis was depression disorder. The recommendations was to start the resident on Remron (antidepressant) 15 milligrams at bedtime. The PLI mental status report for Resident #28 dated 3-23-11 indicated the resident had signs and symptoms of depression and anxiety. The resident was alert and oriented to person, place and month. The resident reported an depressed mood and poor sleep. The updated diagnostic impression was depressive disorder. The recommendations were Zoloft (antidepressant) 50 milligrams every day. Review of the physician recapitulation dated December 2010 for Resident #28 indicated no treatment for depression. Review of the physician recapitulation dated January 2011 for Resident #28 indicated no treatment for depression. Review of the physician recapitulation dated April 2011 for Resident #28 indicated no treatment for depression.		found to have been affected. However, if the DON or SSD find a resident in the future who has exhibited signs and symptoms of depression or is being affected by some other change in condition without a timely physician response, the DON will make sure that the physician is contacted directly at that time so that appropriate orders can be received and put into place. Documentation of that contact and the physician's response will be done in the resident's clinical record. Once the resident is taken care of the DON will review the facility policy with the nurse(s) involved regarding physician notification, including the use of faxes, as well as the expected follow up that is to be done until the time a physician response is received. In addition, progressive discipline will be used for continued noncompliance. 3. What measures will be put into place to ensure this practice does not recur? If a resident experiences a mental or physical change in condition it will be documented on the 24hr. report form and in the focus charting. The focus charting is reviewed at least 5 days a week by the IDT as is the 24hr. report form. Residents who are identified as having changes in condition will have their care plans	

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	The nurses note for Resident #28 dated 12-27-10 indicated the resident yelled out several times "just come and sit with me, and talk, or just give me a hug." The nurses note for Resident #28 dated 3-23-11 indicated PLI recommended starting Zoloft 50 milligrams. A fax was sent to the primary care physician. Interview with Resident #28 on 4-20-11 at 9:00 a.m. indicated he did not do a lot of activities. The resident indicated he slept a lot and laid around a lot and watched TV The resident indicated his daughter died almost a year ago. The resident indicated he was married for forty years and his wife died of Huntington disease. The resident indicated he was remarried, but his wife does not come see him often. The resident indicated he had been depressed for awhile. The resident stated "I ' m depressed, been depressed a lot lately." The resident then requested the CNA to assist him back to bed. During observation Resident #28 remained in his room until 11:20 a.m. when he went to the dining room for lunch. Interview with the Social Service Director (S.S.D.) on 4-20-11 at 12:25 p.m. indicated the protocol when PLI recommends a medication was for a fax to sent to the physician and if the physician		updated at that time. Additionally the IDT will indicate any follow up that is needed at that time, including follow up to recommendations made by other resident care services. The results of those recommendations will be brought back by the designated department manager to the next scheduled morning management meeting for further review as necessary. When residents receive psychiatric services, recommendations and progress notes of that visit will be copied for the DON and SSD for follow-up and physician notification as applicable. The consulting psychiatrist will also review the resident findings with the SSD and DON during the visit itself. If medications are recommended, the physician will be notified at that time. If the notification was by fax, the nurse will follow-up within 24 hr. if no response has been received from the physician, as required per facility policy. A fax tracking log will be implemented to make sure that physician responses are received on a timely basis. (Attachment A). The fax tracking log will be initiated by the nurse responsible for faxing the physician. The tracking log will be reviewed by the DON on a daily basis at least 5 days a week. The log will also be reviewed by the IDT at the morning management meeting	

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	agrees then an order is obtained for the medication. The S.S.D. indicated if the facility does not hear back from the physician within 24 hours, nursing would contact the physician again. Interview with the Director Of Nursing (DON) on 4-20-11 at 12:30 p.m. indicated the physician was faxed on 12-28-10 and 3-23-11 regarding the resident experiencing depression and the recommendation for an antidepressant. The DON indicated the physician did not respond back. During observation on 4-21-11 at 11:00 a.m. Resident #28 was laying in bed watching TV Interview with the resident at this time indicated he did not feel well. The resident stated " I just don't feel good, I don't know how to explain it, I ' m just depressed." " Just down low." The resident indicated he thinks his wife wants a divorce because of his bad health. The resident indicated he had already lost one wife and did not want to lose another one. Interview with the DON on 4-21-11 at 12:55 p.m. indicated she was unable to find that the recommendations made by PLI on 12-28-10 and 3-23-11 was followed up on by nursing to the physician.		that occurs at least 5 days a week. If the physician has not responded within the required 24hr. timeframe, he/she will be notified by phone of the need of a response. If the physician does not respond after this phone call within 4 hours, the nurse or DON will notify the Administrator, who will contact the Medical Director for resolution of the issue. Documentation of all the notifications and response or lack of response by the physician will be placed in the resident's medical record. The physicians will be notified of the required response time frame by the Administrator and DON. What does this mean? When is this notification taking pla 4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The SSD or DON will bring the results of psychiatric recommendations to the QA&A Committee on a monthly basis for review and recommendation. The DON or Administrator will also bring any issues that have arisen in regards to physician response to fax or telephone notifications of resident changes to the Committee for further discussion. The DON or Administrator will follow up as requested by the Committee members and will report the status of	

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	The "Change in Condition" policy provided by the S.S.D. on 4-21-11 at 10:20 a.m. indicated " The resident's primary physician or designated alternate will be notified immediately of any change in the resident's physical or mental condition." The "ESSENTIAL JOB FUNCTION" for social services policy provided by the S.S.D. on 4-21-11 at 10:20 a.m. indicated the "Social Service Functions" included, but were not limited to, identify and seek ways to support the resident's individual needs and preferences, customary routines, concerns and choices, find options that most meet the physical and emotional needs of each resident and meet the needs of grieving residents. 3.1-34(a)		the requested follow up to them at the next scheduled QA&A Committee meeting. This will continue on an ongoing basis. Date of Compliance: 5-21-11	

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F0329 SS=D	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on observation, interview and record review, the facility failed to have an appropriate diagnosis for the use of antipsychotic medication for 1 of 6 residents sample for psychoactive medications in a total sample of 10 (Resident #35). Finding included: Review of the record of Resident #35 on 4/19/11 at 11:10 a.m. indicated the resident's diagnoses included, but were not limited to, anxiety, insomnia, Alzheimer's with dementia, hypertension,	F0329	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Hickory Creek at New Castle desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on 5-21-11. *F329* *It is the policy of this facility that*	05/21/2011

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	155459	A. BUILDING 00 B. WING	04/21/2011

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	asthma, rheumatoid arthritis, and macular degeneration. The Minimum Data Set (MDS) assessment for Resident #35 dated 4-8-11 indicated the following: ability to make self understood - usually understood, ability to understand others - usually understands, disorganized thinking - behavior continuously present, does not fluctuate, physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) - behavior not exhibited, verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others) - behavior not exhibited, other behavioral symptoms not directed toward others - behavior not exhibited, rejection of care - behavior not exhibited, transfer - 2 + persons physical assist, walk in room - activity did not occur, any falls since prior assessment - no, mobility devices - wheelchair, physical restraint - chair prevents from rising/used daily. The "SOCIAL SERVICE MDS SUPPORTIVE DOCUMENTATION TOOL" for Resident #35 dated 10-18-10 indicated the resident's family does not want the resident's medication changed and is against the use of psychotropic medication.		*each residents' drug regimen is free from unnecessary drug, including having appropriate diagnoses for the use of antipsychotic drugs.* *The facility believes that the resident is receiving Zyprexa appropriately and with an acceptable diagnosis to substantiate its use. The facility is requesting a face-to-face IDR for F329. . However a plan of correction has been devised, as per requirements, and is listed below.* 1. What corrective action will be done by the facility? A care plan conference was held with the POA and other family members for Resident #35. The POA has signed the consent for psychiatric services and the physician was notified for the resident to be evaluated by psychiatric services. Facility staff will be re-educated by the SSD and DON regarding the behavior management log, interventions, and documentation on 5-3-11. 2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?	

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	The physician recapitulation for Resident #35 dated March 2011 indicated the resident was ordered Zyprexa (antipsychotic medication) 5 milligrams at bedtime for dementia with delusions, with an original start date of 8-3-10. The physician order dated 3-2-11 for Resident #35 indicated the resident was ordered an increase in Zyprexa to 7.5 milligrams at bedtime. The physician progress notes for Resident #35 dated 3-2-11 indicated the resident yells at times. Increase Zyprexa to see if it helps. The nursing notes for Resident #35 dated 3-2-11 at 12:10 p.m. indicated the resident was very agitated and was unable to be redirected. The resident was undressing multiple times. The resident was taken to the toilet and activities attempted. The resident was tearful at times. The physician increased Zyprexa to 7.5 milligrams at bedtime. The care plan for Resident #35 dated 3-2-11 indicated the resident took an antipsychotic because of dementia with behavioral disturbances. The goal was Zyprexa 7.5 milligrams at bedtime The interventions indicated to attempt to find		All residents receiving antipsychotic medications have been checked and no other resident was found to be affected. From now on, if the DON or SSD find that a resident is receiving antipsychotic medication without evidence of an appropriate diagnosis, the physician will be contacted immediately and made aware of the situation. An appropriate diagnosis will be obtained, or the medication will be changed to something more appropriate, and/or a referral to psychiatric services will be made. 3. What measures will be put into place to ensure this practice does not recur? Residents identified with behaviors will be listed in the log with individualized interventions related to their behavior. The behavior management log will be reviewed and revised by the SSD and IDT to assure behaviors and interventions are identified and appropriate. Each care plan will be updated as applicable with the interventions and medications ordered. The Behavior log and focus charting will be reviewed by the SSD at least 5 days per week to review behaviors and identify if interventions are	

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	the root of the problem, obtain an order for psych services and notify the medical doctor if current medication was not effective. The behavior monitoring record for Resident #35 (no date) indicated the resident exhibited three behaviors that were being monitored. Behavior #1 was the resident becomes combative with care and does not like to be told what to do. The interventions were A. introduce yourself and tell the resident what you are doing. B. Do not rush the resident. C. Offer the resident choices. D. Make sure the resident is safe and let the resident cool off and reattempt in a minute or two. E. Administer medication as ordered. Behavior #2 was the resident was use to being busy and becomes restless when she is idle and will attempt to stand repeatedly without help. The interventions were A. Encourage activities of interest. B. Talk with the resident about the pool she use to have and horses. C. Offer the resident therapeutic work, to help the resident feel busy and purposeful. D. Address any unmet needs. Behavior #3 was the resident removes clothes in the hallway. The interventions were A. Staff will assist the resident with putting clothes on. B. Remind the resident not to undress in inappropriate places. C.		successful. Behaviors will also be discussed at least 5 days per week by the IDT as part of the morning management meeting. If interventions have not been successful a new intervention will be recommended and added to the log and care plan at that time. The SSD will notify staff of the new intervention. 4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The DON and SSD will bring the residents who are receiving antipsychotic drugs to the monthly QA&A Committee meeting. In addition they will discuss the status of residents with behaviors and will review the process in place to monitor the behaviors and the interventions that are being used. The DON or SSD will follow up as requested by the Committee members and will report the status of the requested follow up to them at the next scheduled QA&A Committee meeting. This will continue on an ongoing basis. Date of Compliance: 5-21-11	

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	Offer an activity to redirect. D. Keep the resident dressed in cool and comfortable clothes. The behavior log for Resident #35 dated February 2011 indicated the resident exhibited an behavior on 2-2-11 of hitting at staff and family member in the bathroom. The intervention of letting the resident cool off and reattempt was done and successful. No other behaviors were documented on the behavior log for February 2011. The behavior log for Resident #35 dated March 2011 indicated the resident exhibited an behavior of being combative with care on 3-14-11 . The interventions attempted and were unsuccessful were A. introduce yourself and tell the resident what you are doing. B. Do not rush the resident. C. Offer the resident choices. D. Make sure the resident is safe and let the resident cool off and reattempt in a minute or two. The intervention of administer medication was successful. The resident exhibited an behavior on 3-17-11 of being combative with care. The interventions attempted but unsuccessful were A. introduce yourself and tell the resident what you are doing. B. Do not rush the resident. C. Offer the resident choices. D. Make sure the resident is safe and let the resident cool off and reattempt in a minute			

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or two. No other behaviors were documented on the behavior log for March 2011.

The behavior log for Resident #35 dated April 2011 did not have any behaviors documented.

Interview with family member #1 on 4-19-11 at 1:58 p.m. indicated Resident #35 never had an history of the diagnosis of bipolar disorder or schizophrenia.

Interview with the Social Service Director on 4-19-11 at 3:30 p.m. indicated Resident #35 had not been evaluated by psych services since admission to the facility.

Interview with the Social Service Director (S.S.D.) and the Director Of Nursing on 4-20-11 at 10:05 a.m. indicated Resident #35 did not have an diagnosis of bipolar disorder or schizophrenia.

Interview with the S.S.D. on 4-21-11 at 10:20 a.m. indicated Resident #35's family was aware the resident was taking an psychotropic medication. The S.S.D. indicated during care plan meeting all aspects of the resident's care were discussed with families.

During observation on 4-21-11 at 1:12

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	p.m. Resident #35 was sitting in a wheelchair asleep in the hallway. At 2:30 p.m. the resident was still asleep in the hallway. At 2:35 p.m. CNA #1 and CNA #2 woke Resident #35 up and attempted to take the resident to the bathroom, the resident refused. CNA #1 and CNA #2 attempted to assist Resident #35 into her recliner in her room, the resident held onto the door knob of her door and refused to get in her recliner. CNA #1 put a lap tray on the resident's wheelchair and placed the wheelchair in front of the nurses station. The "Psychotropic Medication Monitoring Program" policy provided by the S.S.D. on 4-21-11 indicated the interdisciplinary team would answer questions for residents receiving psychotropic medication. The questions included, but were not limited to, "Is there a proper diagnosis and indication for use of this medication." The "Nursing spectrum DRUG Handbook" 2010 page 851 indicates Zyprexa is an antipsychotic medication. The Federal Drug Administration (FDA) boxed warning indicates "Elderly patients with dementia-related psychosis are at increased risk for death." "Although causes of death varied, most appeared to be cardiovascular or infectious." "Don't give drug to patients with			

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	dementia-related psychosis." The indications for Zyprexa were "Schizophrenia" and "Psychotic disorders, including manic episodes" and "Maintenance treatment of bipolar disorder." 3.1-48(b)(1)			